Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0543	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING ______	(X3) DATE SURVEY COMPLETED C 02/05/2009
NAME OF PROVIDER OR SUPPLIER: LIVING WELL A COMMUNITY CARE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE: 71 MAPLE STREET BRISTOL, VT 05443		

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R100	Initial Comments: An unannounced, on-site complaint investigation was conducted on 2-5-09.	R100	attched plan of correction	
R116 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.3 Discharge and Transfer Requirements 5.3.b Emergency Discharge or Transfer of Residents (1) An emergency discharge or transfer may be made with less than thirty (30) days notice under the following circumstances: i. The resident's attending physician documents in the resident's record that the discharge or transfer is an emergency measure necessary for the health and safety of the resident or other residents; or ii. A natural disaster or emergency necessitates the evacuation of residents from the home; or iii. The resident presents an immediate threat to the health or safety of self or others. In that case, the licensee shall request permission from the licensing agency to discharge or transfer the resident immediately. Permission from the licensing agency is not necessary when the immediate threat requires intervention of the police, mental health crisis personnel, or emergency medical services personnel who render the professional judgement that discharge or transfer must occur immediately. In such cases, the licensing agency shall be notified on the next business day; or iv. When ordered or permitted by a court. This REQUIREMENT is not met as evidenced	R116	RECEIVED FEB 27 2009	3/18/09

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] 2-26-09 | TITLE: Administrative Assistant | (X6) DATE

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R116	Continued From page 1 by: Based on record review and interview the home failed to notify the licensing agency, by the next business day, regarding the emergency discharge of 2 residents (Resident # 1 and # 2) who presented an immediate threat to themselves and/or others. Findings include: 1. Per record review, Resident # 1's record notes that on 12-26-08 the resident had suicidal verbalizations "give me all those meds". It was also noted that the resident was violent with staff and the physician was notified and crisis team called. The resident was admitted to the hospital that day and the licensing agency was not notified of the emergency discharge the next day. 2. Per record review, Resident # 2's record notes resident "unsafe, no redirectable behavior. " Per interview the Licensed Nurse Aide (LNA) stated on the morning of 2-5-09 Resident 2 " went bizzerk in the bathroom; grabbing staff." The resident was discharged to a nursing home and the home failed to notify the licensing agency of the emergency discharge by the next day. During interview on the afternoon of survey, the home's manager confirmed that the licensing agency had not been notified by the next business day for either Resident 1 or Resident 2.	R116		
R128 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.5 General Care 5.5.c Each resident's medication, treatment, and dietary services shall be consistent with the physician's orders.	R128		

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	0543	A. BUILDING ___ B. WING ___	C 02/05/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVING WELL A COMMUNITY CARE HOME	71 MAPLE STREET BRISTOL, VT 05443

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R128	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on record review and confirmed through interview the home failed to have current, written physician's orders for all medications administered for 1 of 5 residents in the targeted sample. (Resident # 1) Findings include: 1. Per record review, Resident # 1's medication administration record documents that the resident may receive Acetaminophen 325 mg tablets 2 by mouth every 4 hours. The staff confirmed on the afternoon of 2-5-09 there was no written physician's order for this medication in the resident's record.	R128		3/18/09
R136 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.7. Assessment 5.7.c Each resident shall also be reassessed annually and at any point in which there is a change in the resident's physical or mental condition. This REQUIREMENT is not met as evidenced by: Based on record review and confirmed through interview the home failed to assure assessments were conducted in a timely manner for 3 Residents in the targeted sample. (Resident # 1, #3 and # 4) Findings include: 1. Per record review at the time of survey, Resident # 1's last Comprehensive Assessment had been conducted on 6-11-07. Since that time there were notes stating the resident had a recent	R136		

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R136	Continued From page 3 hospitalization for a motor vehicle accident MVA. and the Resident had threatened to harm self with a gun and also threatened to harm others. Neither an annual reassessment or a change in status assessment were conducted by the staff and Registered Nurse (R.N.)of the home. 2. Per record review, Resident # 3's latest Comprehensive Assessment in the record was dated 3-1-07; 23 months overdue. 3. Per record review, Resident # 4's most current Comprehensive Assessment dated 1-16-08, had sections that were left blank, including Section G 5, 6, 7 ,8 and 9 and Section H,I, J, K, L and M. On the afternoon afternoon of survey, the home's manager and R.N. confirmed the above findings.	R136		3/18/09
R145 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.9.c (2) Oversee development of a written plan of care for each resident that is based on abilities and needs as identified in the resident assessment. A plan of care must describe the care and services necessary to assist the resident to maintain independence and well-being; This REQUIREMENT is not met as evidenced by: Based on record review and interview the home failed to assure a comprehensive Plan of Care was developed for 1 of 5 residents in the targeted sample. (Resident # 1) Findings include: Per record review, Resident #1's record included	R145		

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R145	Continued From page 4 a Care Plan dated 11/26/08 that included "suicidal ideation", however no interventions were included on the Care Plan to address the identified problem. This was confirmed by the R.N. on the afternoon of 2-5-09.	R145		

LIVING WELL COMMUNITY CARE HOME
UPDATE ON PLAN OF CORRECTION OF DEFICIENCIES FOUND ON 2/5/09

R128 V. RESIDENT CARE AND HOME SERVICES
5.5c Each resident's medication, treatment and dietary services shall be consistent with the physicians orders. Plan of correction for this deficiency: Administrator or Administrative Assistant will monitor that each resident has signed orders for all medication including supplements and over the counter medications. Staff have been informed via memo and at staff meeting about these requirements. We will also implement an annual medication review with each resident's physician.
The house RN will make sure that these corrections are implemented.

POC accepted on 4-10-09 [illegible] RN

Section 5:3b Discharge and transfer of residents – we have reviewed the state regulations at our staff meeting on 3-18-09 each staff person was given a copy of the 5:3b requirements. Our nurse, Barbara Walling, RN will make sure the plan of correction is followed on emergency discharge and transfer of a resident if the need arises. We will notify the licensing agency the next day. The nurse will be notified by staff in the event that we need to do an emergency discharge.

POC accepted on 4-10-09 [illegible] RN

R1365.7c Resident Assessment and care plans. The nurse will keep a list of the dates the assessments and care plans are due. Our administrator will monitor the nurse to make sure these are done in a timely manner. Copies of the care plans and assessments will be kept in the residents charts.

POC accepted on 4-10-09 [illegible] RN

The nurse will educate the staff at intervals on how to deal with behavior problems and how to keep residents safe in the event we have a resident exhibiting dangerous behavior to self or others.